DOCUMENT RESUME

ED 219 199 RC 013 504

AUTHOR Holseth-Broekema, Karen; Duffey, Martha Pat
TITLE Mental Health Services for Older Adults Living in a Rural Wisconsin Area: Program and Treatment Issues.
PUB DATE 26 Jul 81
NOTE 31p.; Paper Presented at the National Institute on Social Work in Rural Areas (6th, Beaufort County, SC, July 26-29, 1981).

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Clinical Diagnosis; Community Education; Credibility; Depression (Psychology); Grief; *Home Bound; Human Services; Interpersonal Relationship; *Marital Instability; *Mental Health Programs; *Older Adults; Outreach Programs; *Parent Child Relationship; Physical Disabilities; Rural Areas; *Rural Population; Sexuality; Social Work; Social Workers
IDENTIFIERS Gossip; Wisconsin (Waushara County)

ABSTRACT

The report describes a 3-day, two-part (community education and in-home counseling) rural elderly mental health project conducted in Waushara County, Wisconsin, during 1980-81. The first section details activities of the two components and the second section reports the clinician's experiences in the project. As covered in the first section, working with 36 in-home elderly and 308 elderly who attended education sessions results in these findings: (1) 86% suffered from depression (17% from loss of loved ones, 21% from marital problems, 48% from health problems); (2) accurate assessment required contact with other agencies; (3) establishing trusting relationships took longer than expected; (4) home settings promoted rapport; (5) in-home counseling was expensive, but necessary; (6) elderly were receptive to the education component; and (7) gossip was an unanticipated problem in the education component. In the second part, the clinician tells of her project experiences in working with elderly marital problems, sex counseling, parent-child relations, and chronic mild depression. The report concludes that the assignment of a particular clinician to work with the elderly strengthened the clinician's sensitivity to elderly issues and enhanced visibility within the community; however, the strain and emotional drain on the clinician were great. (AH)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED219199

AUG 1982
RECEIVED
ERIC/CRESS

MENTAL HEALTH SERVICES FOR OLDER ADULTS LIVING IN A RURAL WISCONSIN AREA: PROGRAM AND TREATMENT ISSUES

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Karen Holsath-Brookema

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Karen Holsath-Broekema, M.S.W.
Martha Pat Duffey

Waushara County Guidance Center
P.O. Box 700
Wautoma, Wisconsin 54982

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

This document has been reproduced as received from the person or organization originating it.

Minor changes have been made to improve reproduction quality.

Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

RC013504

Paper presented at the Sixth National Institute on Social Work in Rural Areas
Beaufort County, South Carolina
July 26-29, 1981

The first half of this paper describes program issues of the Waushara County in-home elderly counseling project and was written by Martha Pat Duffey, Program Director of the Waushara County Unified Services Board.

In the last half of the paper treatment issues are presented by Karen Holseth-Broekema, M.S.W. who was and is the clinician in this ongoing program.

INTRODUCTION

Unified Services programs provide 16 services to the mentally ill, the developmentally disabled, and the alcohol and drug abuser. Although the programs are theoretically controlled and operated by the counties, most of the funding comes from the state. There is a required county match and the degree to which the county surpasses that match really determines the degree of local control, particularly for small counties. Waushara County, although rural and conservative, far exceeds the required match. There is a one million dollar budget to serve a county with a total population of less than 20,000.

Waushara County, which covers 640 square miles, is located in central Wisconsin lake country. The county is sparsely populated with the current population of the largest city being 1600. The main sources of income for the 18,535 people who live there are tourism and farming. The biggest cash crops are pickles, peppers, potatoes and strawberries. Waushara County is also reputed to be the Christmas tree capital of the United States. But, Waushara County is not a rich county. The average income is 30% below the state average. That is quite low even though Wisconsin is a relatively affluent state.

There is a large elderly population. In 1978 the state estimated that 24.1% or 4,053 of the residents in Waushara County were over 60. The director of the local Commission on Aging is certain the 1980 census figures will support that estimate.

BEST COPY AVAILABLE

History of Project Development

The idea for a project to meet the mental health needs of the elderly in Waushara County was developed in October of 1978. The director of the county Commission on Aging suggested that the county mental health agency might want to submit a request to the Commission for funding under the Older Americans Act. The administrator of the outpatient clinic and the director of Unified Services assessed the degree to which the elderly were receiving outpatient services. In-house statistics indicated that during 1978 only 5 individuals over 60 had received services from the clinic. That was only 2.3% of the 220 cases that had been opened that year. After more study and considerable planning, Unified Services submitted a $20,000 2-part proposal to the Commission. Additional mental health services would be provided to the elderly through a program which would operate three days a week under the supervision of the clinic administrator. The two components of the program were to be community education and in-home counseling. The in-home counseling was to be the most important aspect of the service.

The Commission did not fund the project. It was expensive considering that only 22 people were expected to be served through the in-home counseling. In addition, the more vocal seniors were lobbying for transportation and senior center funding.

The proposal was filed away. Then, in the summer of 1979, the state announced that $310,000 in Title XX funds was available for approximately 10 demonstration projects. The first proposal was retrieved and its concept revived by soliciting support from the Unified Services Board, the Commission on Aging and other human service agencies. The

BEST COPY AVAILABLE

end result was that a decision was made to expand the original proposal into a full grant application for a demonstration project.

Problem Statement

As in the previous proposal, the problems of the elderly were still assumed to be declining health, declining income, increased isolation, increased leisure time, lack of transportation, the loss of family and friends, and finally, their own deaths. It was also still assumed that the elderly did not seek out mental health services for two major reasons. The first and most obvious assumption was that they were simply unaware of the services. The second assumption was slightly more complex. The elderly were attributed with a fierce determination to remain independent. That conclusion, coupled with the fact that this group had grown up during an era when mental and emotional problems were an embarrassment, led to the assumption that the elderly simply refused to come to a mental health clinic. These assumptions may have been somewhat erroneous.

The 1978 figures indicating that only 5 persons over 60 had received clinic services still applied. But, when talking with personnel from other agencies about the proposal, an assurance was given that a caseload was 'waiting in the wings' if home visits could be made.

Project Goal

Since the perception of the problem had not changed, the goal of the project was not changed. That goal was to begin meeting the unmet mental health needs of Waushara County's elderly during a one year grant period.

BEST COPY AVAILABLE

Project Design

The original project design of a 2-part 3-day program was also maintained. Again, the 2 parts were community education and in-home counseling, which were to be provided by an M.S.W. or someone at a comparable level in a related field.

The community education was to consist of presentations regarding mental health problems among the elderly, recognizing symptoms of those problems, the local services that were available, and wellness concepts. The obvious places to make the presentations were senior citizen centers, nutrition sites and elderly housing units. It was thought that if the elderly became acquainted and comfortable with the therapist they would be more likely to seek services if needed. In other words, the presentations were expected to generate clients.

The projection was that the therapist would spend 40% of his/her total time working in the educational component of the program, with more time devoted to this aspect during the first 6 months of operation. The objective was to reach 500 individuals since the Commission on Aging had advised that there were 730 unduplicated individuals attending senior citizen centers or nutrition sites and living in elderly housing.

A simple one page questionnaire on the content of the presentations was to be developed. It was to include a mixture of questions regarding attitudes and information. By asking those in attendance to complete the questionnaire before and after the presentation, an indication of its impact was to be obtained.

It was anticipated that the in-home counseling component of the program would serve at least 22 people. This would have been more than four times the number receiving services during 1978. There was also speculation as to which agencies or groups of individuals would make

BEST COPY AVAILABLE

referrals and how many would come from each.

It was further anticipated that the therapist would spend 60% of his/her time in providing direct services. Half of that, or 30% of the total time, would be spent making home visits. For project purposes direct services included the in-home counseling, collateral contacts, case consultation, clinical supervision, staffings and paperwork.

Documentation Required for Evaluation

Documentation was required for each of the project objectives. This was accomplished through detailed record keeping and quarterly monitoring reports.

Results

Many of the assumptions that were made were not entirely correct. But, this was not research. It was simply the demonstration of an idea. Consequently, definitive generalizations about the elderly cannot be made. The following is merely the result of the Waushara County project.

First, the county nurses began making referrals the day they were notified the grant had been received. By the time a therapist was hired 10 referrals were waiting. That was almost ½ the number of clients to be generated during the entire year. The nurses previously had stated they had referrals but they neglected to mention how many. In fact, they referred 19, or 53% of the 36 individuals who received services. In contrast, the COA had been expected to make the most referrals. It was not surprising that, given the referrals from the nurses, the number of clients served during the initial year grew to 36, more than 1½ times what had been anticipated.

The impact of this referral pattern was that most of the clients were so physically disabled that it would have been difficult, if not

BEST COPY AVAILABLE

impossible, for them to come to the clinic, if they had wished. You may recall the assumption that the elderly avoided the clinic because of stubborn independence and social taboos. Of course anyone else thinking of initiating a similar program must be cautioned that these results may have easily been influenced by the number of referrals from the county nurses. Another possibility is that maybe the elderly <u>are</u> extremely independent. Maybe they won't use mental health services until the situation becomes desperate due to a physical disability. Another point to consider is that possibly the rural elderly are emotionally healthier than expected. Coping skills could have been so finely tuned over the years that the need for mental health services didn't become crucial until there was a physical disability, or some other crisis situation such as loss of spouse or significant other.

As might be imagined, with the large caseload generated not only by the nurses but others, it became necessary for the therapist to spend 94% of her time in direct services. While the objective was to serve 22 individuals during the project period, by June 30, 1980, three months after the project started, the caseload was up to 15 and by September 30 it had gone beyond the original goal to 25, with 5 cases having been closed. At the risk of being repetitious, it should be stated again that by the end of the project period 36 individuals had received in-home counseling services.

Summary of Treatment Findings

It is common knowledge that the most common psychopathology found in the elderly is depression, particularly depression caused by external stress. Eighty-six percent of the clients who received services through this project were suffering from depression. Grief reactions due to the

BEST COPY AVAILABLE

loss of someone dear to the patient are reported to be the most common causes of depression among the elderly. This was not true for the project clients. Only 17% of the people receiving services through the project were depressed due to the loss of someone near and dear. Twenty-one percent were experiencing depression related to marital problems, a totally unexpected development. And, 48% were suffering from depression related to significant health problems. The clients in this last category did not respond as quickly to treatment as the others. Even so, it was necessary to treat only one of these clients with anti-depressants and to hospitalize only two briefly.

One aspect of the treatment process that the therapist found to be especially critical was accurate assessment. Health problems, medications being used, experiences of a long life, and current financial and social supports were all factors that had to be considered. Collateral contacts with other health and human service professionals were important in order to obtain accurate and complete information for assessment, as well as coordination of treatment. The Ph.D. psychologist who consults at the clinic eight hours per week specializes in geriatric problems. He and the therapist were originally scheduled for monthly case consultations. This was a valuable resource but monthly meetings proved to be unnecessary, although he was consulted in two cases regarding effects of acute cerebrovascular accident (stroke). The staff psychiatrist was also available for consultation and treatment.

It is understandable that assessment was often difficult and time consuming. Other obstacles were also encountered that made assessment a lengthy process. The therapist felt that it took the elderly longer to establish a strong trust level in addition to the fact that the older person simply operates at a slower pace. Nothing can be done in a rush.

BEST COPY AVAILABLE

One aspect of the project format that proved to be particularly helpful in making assessments was working with the client in the home setting. Despite the complexity of assessment and the reserved nature of the elderly client in Waushara County, the perception was that rapport was established more quickly by working in a setting where the client felt comfortable. The therapist was also in a position to obtain a more complete picture of the client's total lifestyle. Family photographs and personal mementos were useful not only in making assessments but also during treatment.

Regarding actual treatment, it was often found that traditional approaches to psychotherapy were not appropriate except during initial sessions. A behavioral approach was generally taken in order to deal with the lack of motivation, initiative and activity so characteristic of depression. The goal was to have the client either modify an old behavior or develop a new one. To do this, the level of activity had to be increased. A lot of time was spent in identifying activities that had been enjoyed by the client in the past and being creative about what was possible for the present. The therapist often had to be the catalyst that generated an activity. There were times when this was as basic and directive as helping the client to dress and literally leading the person out of the house. Other types of activities used were simply local pastimes like swimming and strawberry picking. Positive behavior was always reinforced.

In instances when the activity itself wasn't sufficient reinforcement, the therapist became a reinforcer, a social reinforcer. One case provides a perfect example. The client finally agreed to go to a restaurant but only with the therapist whose company was the reinforcing aspect of the activity. But, eventually, the activity itself became so

BEST COPY AVAILABLE

reinforcing or enjoyable that the client began going to the local nutrition site with friends.

Summary of Educational Program Impact

It is understandable that the community education component of the project did not turn out quite as expected. Instead of spending 40% of her total time in the educational program, the therapist was able to work in that area only 6% of the time. That was considerably less than the 40% projection. As mentioned earlier, the conclusion was that this was due primarily to the unexpected and immediate demand for direct services.

The educational presentations did not reach 500 people. But according to project records, which were based on numbers and not names, a minimum of 308 individuals attended at least one presentation. If confused by the statement that the count was based on numbers, not names, the process can be made clearer by example. If a presentation was made on 3 different occasions at the same senior center, the total present for only one of those programs was figured into the count.

The questionnaire developed for use before and after the presentations was relatively useless. Specifically, the elderly found the pre- and post test format (designed to measure learning) especially objectionable saying, "Why should I fill this out again, it's the same thing." So, for awhile the questionnaire was used at the beginning of the presentations only. Then its use was stopped altogether, partly because it seemed to be a waste of time and also because some content changes were made in the presentation.

The grant proposal mentioned a limited number of topics to be used in the educational presentations. Again, they included mental health problems of the elderly, local services that were available, and wellness

BEST COPY AVAILABLE

concepts. The therapist initially made brief introductory presentations about the new service at the county health and human service agencies, the senior centers, the nutrition sites and the elderly housing units. Then she began making the rounds again with the full educational program. The therapist took this approach because she had been advised by people who worked with the elderly that she might run into resistance. She decided that a casual, friendly style would be more readily accepted. It was. That approach proved to be a good one.

Although the presentations went well, it wasn't long before the therapist had circulated through all the senior centers, nutrition sites and housing units twice. In an effort to maintain contact with the community, additional topics were developed for presentation. Films were useful. One, Art of Age, illustrated how to enjoy a productive and rewarding retirement. The reaction of the audiences was quite positive. Another film, A Rose by Any Other Name, was used once toward the end of the project year. The topic was sexuality and aging. Lively discussion followed. The therapist did state that the positive reception may have been due in part to the fact that no advance notice was given as to the topic. In addition, a local Baptist minister, who was present by chance, proved to be invaluable during the discussion after the film because of his openness and acceptance of sexual needs in the elderly. The therapist even entertained the idea of asking the minister if he would consider duplicating "the discussion" each time the film was used in different sites.

A minor (but important) aspect of the educational program developed from an unanticipated problem area. The longer the therapist worked with the rural elderly the more aware she became of the role gossip played in their lives. For some, it was not only a pastime, but an obsession.

BEST COPY AVAILABLE

Cliques formed wherever the elderly gathered, particularly in the housing units. And, unfortunately, the gossip was not totally harmless; at times it was really hurtful. In response to this development, an article about gossip was reprinted in the newsletter published by the Commission on Aging. The article had an impact. A series of posters dealing with the negative aspects of gossip was also ordered and placed in all the elderly housing units throughout the county.

Also of interest is another series of presentations begun after the grant period ended. The therapist worked with the county home economist in making a 3-part presentation on nutrition and exercise. The segment on exercise was presented by the therapist and she demanded audience participation.

Another activity requiring physical exertion had been planned for the winter. Materials on cross-country skiing for the elderly were obtained and arrangements were made for a program of instruction to be monitored by the local physician's assistant. The local sports center was even persuaded to give senior citizens a discount on rental equipment. Unfortunately, the program had to be cancelled due to an unusual lack of snow. Weather providing, this program will be reintroduced next year.

Conclusions and Future Programming

A few observations and conclusions made by all who were involved with the project should be summarized. The elderly population in Waushara County, both the individual clients and those attending the community presentations, was much more receptive than anticipated. The therapist can take at least part credit for that outcome. Although outreach services are undoubtedly more expensive than center-based, the conclusion was that these people would not have been reached without this

BEST COPY AVAILABLE

type of service. Given some of the physical disabilities encountered, it would have been literally impossible for many of the clients receiving in-home counseling to come to the clinic.

Again, the value of working within the home environment must be emphasized. Considering the limited support system available to many of the elderly, the therapist has an opportunity to have real impact.

In the future (since the county has decided to continue the service with local funding) it is hoped that the therapist will have an opportunity to spend more time in community education. There are two reasons for this intention. One is that a gradual decline in the number of referrals from the county nurses is expected. Their most severe and urgent cases are being served. Another is the assumption that there are emotional problems among the more active elderly. If the therapist had been able to spend more time with that segment of the community it is possible that many would have become clients. The third reason is the impact on the therapist of working 3 days a week with clients -- all of whom are depressed. This is depressing. The current therapist is a vital, energetic, physically fit person. She was a terrific influence on the clients. But, her particular personality may have also been the reason she found all the physical disabilities and depression difficult. It may have been different for someone who wasn't so oriented towards physical fitness.

Finally, when the Waushara County project was developed there were only 3 other programs specifically directed at the mental health needs of the elderly operating in the State of Wisconsin. Of these only one, which was located in an urban area, offered in-home psychotherapy. A second program, which was also operated in an urban setting, provided information and referral, but no therapy. The third program was located

BEST COPY AVAILABLE

in a 3-county area but the service provided was volunteer peer counseling only.

Over the past year Unified Services has received numerous requests from throughout the state for information about the approach used in Waushara County. This approach may not be as economical as volunteer peer counseling or reach as many people as information and referral, but it may well have the most long lasting impact.

BEST COPY AVAILABLE

TREATMENT ISSUES

Initially a formal paper was begun which attempted to describe the experience of one therapist involved in a special outpatient therapy project with a rural elderly population. This paper was abandoned in part because the presentation at the Sixth National Institute on Social Work in Rural Areas, which precedes these comments, adequately described the basic program and community education features of this project. The original paper was discarded also because clinical interest at the Institute focused on the therapist's experience with marital problems in the elderly, sexual counseling, and parent-child problems.

These experiences are addressed in the informal paper which follows. The clinician's work with chronic mild depressive clients is also included in order to elaborate upon the presentation of this entity in the foregone transcript.

It should be noted that a systems approach to treatment was utilized in a majority of cases.

Marital Problems

The predominant observation of couples encountered in this project was the relationship between a dysfunctional marriage and personal care of a disabled spouse. In our experience we came across marriages where one individual was quite severely disabled (with crippling arthritis, stroke, progressive and deteriorating diabetes) and the other spouse was more healthy and functioning in the role of caretaker. Obviously this caretaker role is a common occurrence in today's society. The situation,

BEST COPY AVAILABLE

however, is complicated when the marital relationship is not strong. Constant demands for assistance by one partner of the other partner becomes a burden in any relationship. Even the minor disability of hearing loss, making constant repetition necessary, causes irritation in most people. In our experience many disabled spouses were in wheelchairs or even confined to bed. They were extremely, and in some cases totally, dependent on the stronger, healthier caretaker spouse.

In all cases the referral reason was depression in the disabled spouse or "lack of adjustment to illness". Upon assessment, the depression was found to be related more to marital dysfunction than physical dysfunction. It is obvious that a tremendous shift in power occurs in these marriages. It is possible that some feelings of vengeance may frequently be experienced by the caretaker; especially in those instances in which the disabled person had been domineering in earlier years of the relationship. Total dependency and fear of reprisal made these disabled people victims. When they made demands, or were perceived as complainers by their spouses, they were often left alone for protracted periods of time or elements of personal care were neglected.

Intervention is extremely difficult in these cases. Often we are dealing with long-term patterns of behavior and communication developed during 40-50 years of marriage. In two cases traditional marital therapy was undertaken with some degree of improvement in personal care as frustrations were ventilated, mutual consideration/cooperation was encouraged, and individual support was provided by the therapist. In two other marital cases the therapist's role evolved into individual work with the disabled spouse. Work concentrated on improving life satisfaction and the general quality of life. A volunteer "friendly visitor" was added to the person's life, visiting once weekly to increase potential for

BEST COPY AVAILABLE

social interaction.

Program and psychotherapy implications of the above finding may be formulated by practicing clinicians and agencies. This therapist's opinion is that outreach in senior gathering places is appropriate, in order to discuss the issue of personal care needs of many elderly, the ramifications of the marital problems, and availability of services. The key to this particular problem area is clearly early intervention.

Parent-Child Problems

Two cases were encountered where parent-child problems existed. In the first a marital couple (aged 71 and 60) had requested services for a son who was 17 years of age. It quickly became apparent that although the son was experiencing difficulty in a number of areas, there was a call for marital therapy and later family therapy. Intervention was similar to the manner in which any family therapy oriented clinician would intervene. Again, it bears repeating that therapy approaches need be no different with this age group than with other ages. It may, however, take a little longer to establish the credibility of psychotherapy and trust in the therapist. Treatment may also progress more slowly because of the long-standing patterns of behavior and cognitive processes.

The second parent-child case involved children who were taking financial advantage of a widowed mother. An attempt was made to work with the mother and one child, but eventually the therapist concentrated on individual work with the mother. Psychological dynamics addressed were self-esteem, independence, and exaggerated guilt. Once these areas were explored and support provided, depression decreased and the woman was able to deal more effectively with her children.

BEST COPY AVAILABLE

Sexual Counseling

The main case in which sexual issues were addressed was an 82 year old widowed woman. Her concerns arose when she began to develop a relationship with a man who was a widower. The individuals had been friends when their spouses were still alive. The woman was extremely open and direct with the therapist about crucial issues related to human sexuality in general. She described a need for affection, intimacy, and emotional fulfillment through sharing. What also concerned her were mores for appropriate female behavior in this society. To be specific, she wanted to discuss the issues of who should initiate gestures of affection: the man or the woman. She desired closeness, but not the sexual intimacy of intercourse. The manner us to how to explain herself to the man was one of her major concerns. She was most worried that if she communicated her feelings directly with him in these matters she may be perceived as "forward" or "unfeminine".

Basically, these issues are no different than those faced by adults of any age. The therapist must first be completely accepted by the client, and trust established. Perhaps in work with the elderly the trust issue is more important, especially concerning the area of human sexuality. Of equal importance is the therapist's comfort level in discussing sexual issues. Conveying the concept to the older adults that these are natural feelings seems to quickly open up the subject which they appear relieved to discuss.

The other case in which sexual issues arose was with a couple who had been married for nearly 43 years. Initially it seemed the physical disability of the wife was a major contributing factor since she was confined to a wheelchair and was severely disabled from arthritis. Very quickly, however, it became clear that the major problem was a

BEST COPY AVAILABLE

marital relationship that had been dysfunctional for at least 35 years. Marital therapy was the primary need in this case. Following the treatment recommendations of Masters and Johnson it first became necessary to address the issue of communication and intimacy in the couple's marriage before attempting to improve the sexual relationship. The marital relationship and communication were the crucial issues in this case because they exerted great impact on the wife's physical care, which was provided by the husband. These factors also contributed to the wife's poor adjustment to her physical limitations. Other members of the family told the therapist how she had "given up" quickly in the area of physical therapy (i.e. rehabilitative measures); thus as a result possibly prolonging the need for confinement to a bed and wheelchair. The impression is that marital therapy, provided years ago, could have exercised a positive impact on the woman's adjustment to the permanent disability which she was currently experiencing. Some work was done with her husband individually in the area of sexual fantasy involving a woman with whom he had been involved prior to marrying his wife 43 years ago. Again, it should be noted that trust in the therapist is undoubtedly a significant factor, since this work was done with the husband 8 months after the initial visit.

When the issue of sexuality in aging was discussed with members of a local senior center group, these people were more reticent to share their feelings. Statements made by the elderly tended to indicate that they believed social myths such as decreased interest in sexual expression, sexual fulfillment, and intimacy as adults become aged. Before the therapist left the senior center that day several people came up to privately share their personal experiences and needs. It should be noted that the therapist was familiar with these people because of the frequent

BEST COPY AVAILABLE

visits to the center. These experiences certainly point to a need for more discussion and educational efforts in this area.

Chronic Mild Depression -- the Unmotivated Client

This individual lives an unfulfilled life and suppresses healthy desires for closeness and mutuality. The person often suffers from a chronic sense of futility and hopelessness because he/she does not allow himself/herself to become involved in rewarding activities. Someone with this long-standing pattern of depression typically becomes a long-term client of the therapist (or family doctor, as many seek frequent medical attention).

This therapist and others have noted that loss of positive motivation is often a striking feature of depression (Beck, 1967).[1] As Dr. Beck reports, ". . .occasionally. . .a shift in a patient's life situation may serve to mobilize his constructive motivations."[2] To facilitate a shift or movement in the client's behavior became a basic intervention goal. This goal was part of a therapeutic process, however, that began first with assessment. The issue of motivation is tied closely to the notion of psychic energy, coping skills, and attitudes. In Dr. Beck's book on depression he describes a depressed person's tendency to make negative conceptualizations, and thus is prone to experience a negative mood. He states, ". . .as long as he expects a negative outcome from any course of action, he is stripped of internal stimulation to do anything."[3] How to facilitate some change in the person's life then becomes a major

---

[1]Aaron T. Beck, M.D., Depression: Causes and Treatment (Philadelphia, Pennsylvania: University of Pennsylvania Press, 1967), p. 27.

[2]Ibid., p. 28.

[3]Ibid., p. 263.

BEST COPY AVAILABLE

goal in treatment. The therapist may act as a catalyst to redirect the client from self-preoccupation to an interest in the outside world. The potential for this begins during the assessment phase. By utilizing active listening skills to establish trust and relax the elderly person to the newness of relating to a mental health practitioner, the clinician is able to collect a body of data required for an accurate assessment, but is also well underway in the treatment process. This clinician used traditional psychotherapy primarily in initial interviews and on a limited basis during subsequent interviews. In these early sessions the traditional stages of reassurance, ventilation, and guidance were explored.

In later sessions the remainder of work with the client generally relied on a behavioral approach to treatment. Basic behavioral principles utilized were reinforcement of positive behavior and reinforcement of the acquisition of new skills. It is difficult to facilitate change in this type of client by relying entirely on traditional psychotherapy. In cases of mild depression in particular, the individual seems able to shift his/her attention rapidly to the therapist, which is helpful in stimulating movement.

Part of the psychosocial data collected by this therapist was not only information concerning social support systems, but also reinforcement contingencies operative or previously operative in the individual's environment. Useful data includes activities frequently performed and enjoyed, or activities that had improved the quality of life and were no longer available or utilized. Previous coping skills were carefully explored. Sometimes the older person being evaluated looks very different from the person he or she was even one or two years earlier.

Applications of reinforcement contingencies to treatment issues deserves further elaboration. Once some degree of ventilation had taken

BEST COPY AVAILABLE

place, the therapist proceeded to the stage of behavior change, and in some cases the acquisition of new behavior. One goal in the majority of cases was to increase activity level. Increasing the individual's activity level makes it more difficult to maintain the current level of depression. This was the case whether clients were experiencing depression related to grief or to a major physical disability. Utilizing information collected regarding what activities had been naturally reinforcing to the client in the past is a likely place to begin. Can the therapist encourage the client to attempt this activity again? In some cases several months or years may have passed since the client had become engaged in this activity. Identification and utilization of reinforcers, whether they are activities or social reinforcers, is an area in which the therapist may use his or her creative clinical skills to assist the client. This is critical in view of the client's current reduced energy and motivation. In some cases the client is extremely limited in terms of identifying or engaging in activities which will be reinforcing and catalysts for more activity.

In contrast to younger clients served through conventional outpatient settings, elderly clients often possess a limited number of significant others in their lives to serve as resources to assist them in confronting depression. Therefore, the therapist has the potential for greater influence and impact. The therapist demonstrates interest in the client's welfare (and establishes self as a reinforcer) by a willingness to visit the client in the home with consistent and frequent contacts. At times, in order to stimulate an increased activity level, it might be necessary to help the client to eat with friends or attend a local mealsite. Again, the client described in this discussion is the individual characterized as possessing low motivation and is often much less active because he/she

BEST COPY AVAILABLE

experiences a significant health problem. In some instances the client does not experience a serious health concern but has low motivation, coping skills, and is either self-limiting (appearing much older than his/her stated age) or showing psychosomatic or hypochondriacal symptomatology. In any of these cases the same approach is useful: i.e. therapist using self as catalyst or reinforcer.

There are both pros and cons to assigning a particular clinician to work with elderly clients in the manner described in this paper. Advantages include increasing the clinician's sensitivity and awareness of advanced age issues, strengthening his/her visibility in the community, as well as acceptance by older adults. An important advantage includes the clinician's development of a special expertise in working with depressed older adults. One disadvantage of working predominantly with depressed older adults is the tremendous emotional drain experienced by the clinician. Often these elderly are in dire financial circumstances or debilitated health and it is clear improvement is often unlikely. Gains are often small and it is impossible not to be touched by the sadness surrounding these situations. In this clinician's opinion, working more than three days a week with these clients would be difficult. In the current program, a 3-day week workload allowed the clinician sufficient time to revitalize. The clinician's energy is essential for working effectively with this population.

Working with this group is extremely rewarding as clients are invariably appreciative. This work is especially challenging as it does require creativity and innovation. Much variety is experienced with in-home counseling as the therapeutic millieu is constantly changing. There is a "new frontier" quality about the work. Finally, there can be tremendous satisfaction in arriving at a better understanding of the later

BEST COPY AVAILABLE

stages of the life cycle and thus the total life process. The transitions and tasks of later life hold the potential for loss and dysfunction, but also for transformation and growth. The power of attitude in the older adult is a determinant, but the attitude of the clinician is an important factor as well.

BEST COPY AVAILABLE

RESOURCE MATERIALS

Arieti and Bemporand, Severe and Mild Depression: The Psychotherapeutic Approach. New York: Basic Books, Inc., 1978.

Beck, Depression: Causes and Treatment. Philadelphia: University of Pennsylvania Press, 1967.

Busse, "Aging and Psychiatric Diseases of Late Life", in Reiser (Ed.) American Handbook of Psychiatry (Vol. 4). New York: Basic Books, 1975.

Busse and Blazer, Handbook of Geriatric Psychiatry. Duke University Medical Center: Van Nostrand Reinhold Company, 1980.

Carter and McGoldrick, The Family Life Cycle: A Framework for Family Therapy. Gardner Press, Inc., 1980.

Cohen, Gene, M.D., "Mental Health Services and the Elderly: Needs and Options", American Journal of Psychiatry 133.1. January, 1976.

Films:

Art of Age,[1] 27 min. A.C.I. Films, 1972. Film was rented from: Bureau of Audio Visual Instruction, University of Wisconsin--Extension, Box 2093, Madison, WI 53701.

Peege.[2] Phoenix Films, Inc., 1974. 470 Park Avenue South, New York, NY 10016. A film showing how difficult it is to communicate with someone whose health is deteriorating and is nearing death.

Rose By Any Other Name. Adelphi University: Center on Aging, Garden City, Long Island, NY 11530; 516-485-6730. A film addressing the issue of sexuality in aging.

A Yellow Leaf and I Think They Call Him John.[3] Mass Media Associates, Inc., 225 South Main Street, Box 427, Stewartstown, PA 17363. Films illustrating how aging, loneliness or being a widow/widower can leave a person without goals and literally wasting away. (Description of films on following pages.)

---

[1]We were told A.C.I. Films is no longer in business and was purchased by Paramount Pictures, 1136 North Las Palmas Avenue, Hollywood, PA 90038. Other major film rental agencies may also have copies of the film.

[2]Films not used during the course of this project which may be used in the future.

[3]Ibid.

BEST COPY AVAILABLE

Frankel and Richard, Be Alive as Long as You Live. New York: Lippincott and Crowell Publishers, 1980.

Galton, The Truth About Senility and How to Avoid It. Thomas Crowell Publishers, 1979.

Glasscote, Gudeman and Miles, Creative Mental Health Services for the Elderly. Washington, D.C.: a publication of the Joint Information Service of the American Psychiatric Association and the Mental Health Association, 1977.

Hartog, Audy and Cohen, The Anatomy of Loneliness. New York: International Universities, 1980.

Heidell and Kidd, "Depression and Senility", Journal of Clinical Psychology; 31 (1975).

Huyck, Hellie, Growing Older. Prentice-Hall, Inc., 1974.

Hussian, Geriatric Psychology: A Behavioral Perspective. Van Nostrand Reinhold Company, 1981.

Keleman, Stanley, Living Your Dying. Random House, 1974.

Merrill, Activities for the Aged and Infirm. Charles C. Thomas, Publisher, 1967; Sixth Printing, 1979.

Pamphlets: (free)
Cross Country Skiing for Older Americans. Mr. Howard Peterson, U.S. Ski Association, Box 777, Brattleboro, VI 05301.

Post, "The Clinical Psychiatry of Later Life". London: Pergamon Press, 1965. In Salzman and Shader, Psychiatric Symptoms and Cognitive Loss.

Posters:
"Respect for Others" (gossip). See copy of posters on following page. Spenco Medical Corporation, P.O. Box 8113, Waco, TX 76710.

Raskin and Jarvik, Psychiatric Symptoms and Cognitive Loss in the Elderly: Evaluation and Assessment Techniques. Washington, D.C.: Hemisphere Publishing Corporation, 1979.

Vickery, Old and Growing. Charles C. Thomas, Publisher, 1978.

BEST COPY AVAILABLE

MASS MEDIA

Mass Media Associates
Box 427
Stewartstown, PA 17363

Mass Media Associates
Box 427
Stewartstown, PA 17363

presents

"A Yellow Leaf"

CREDITS: Produced and directed by Ronald W. Rowart. 1973. Rental: Sale:
Running time: 14 min. in b&w. Rent or purchase from Mass Media.

SUMMARY:

The life of one weary woman in her seventies, having been reduced to the slight rhythm of an antique rocking chair, falls into poetic perspective. Along with spoken verse and rhyme heard off-camera, the woman's withered hopes and bitter sweet memories are woven into an intricate tapestry with the quaint relics from her past that now decorate her lonely habitation. Nostalgic sounds dominate the audial backdrop -- a train taking her one-time lover off to war, the gunfire in Flanders Field that ended that early romance, the parade that celebrated the Great War's end, the waves against the shore of the cottage-by-the-sea she always wanted but never had. Enfeebled hands reach for medication on the table. A scrapbook lies unopened. An unused crib symbolizes a childless marriage. A clock on the wall ticks and chimes. A cemetery beckons.

COMMENTS:

The smell of death is unmistakably attached to every frame of "A Yellow Leaf." The production plays as if it were an awesome requiem, sung in honor of the lost potential of a woman pathologically enslaved to her past. A distinctive use is made of the element of repetition in the visual images, a repetition akin to that which is used in musical refrains or in liturgical music more specifically. Emotions should be allowed to be a major part of a group's reaction to the film, as they respond to and work through the precise and sensitive expression of feeling that it all becomes. Then perhaps in the course of discussion a path should be steered toward a more objective appreciation of all that has made this woman what she is, both internal and environmental. There is more than the death of a woman being mourned, and the viewers might strive to give definition to what else is, dead or dying.

AREAS OF USE:

In terms of age level, the film confines itself to adult usage. It is especially communicative with those over fifty, but it ought to speak to any adult who has reached that stage where he has become aware of the pastness of youth and the inevitability of eventual death. This would embrace many of the anxieties and losses of innocence about life that occur for people in their forties. In discussion the quality of the material lends itself to subjects such as the impact of change, individual dignity, loneliness, love's sacrifices and extremities, the role of the female in society, finding life's priorities, and of course the subject of aging and death.

QUESTIONS FOR DISCUSSION:

1. Try to envision all the factors that together have contributed to this old lady being the alienated and haunted person she has become.
2. To what extent has she done it to herself?
3. If this woman has been somewhat self-destructive in the way she has lived, why do you think poetry is used? The poetry has an exaltant sound to it. What's being exalted?
4. What strengths, the corresponding opposites of this woman's weaknesses, are common to many aged and senile people?
5. What can future generations learn about values from this depicted example?

BEST COPY AVAILABLE

MASS MEDIA ASSOCIATES

Mass Media Associates
Box 427
Stewartstown, PA 17363

Mass Media Associates
Box 427
Stewartstown, PA 17363

presents

"I Think They Call Him John"

CREDITS: Produced by Jack Carruthers (1970). Directed by John Krish. Running time: 26 min. in b/w. Rental: Sale: Rent or purchase from Mass Media Associates.

SUMMARY:

One drab, lonely Sunday in the life of an old miner, a widower on pension and without children, gives evidence of how retired life is for so many. John has special memories attached to Sunday, for it was the day on which as a child he was accustomed to being surrounded by neighbors and relatives as they came to call. But on this particular Sabbath he is only seen by the invisible eyes of those who view the screen. From sun-up to sundown he moves about in his London flat (the film is British) making a life for himself out of lackluster meals, preparing for guests who will never come, reading a token letter from a distant relative (the narrator commenting, "There is one advantage to growing old. There are not as many letters to answer"), napping in the afternoon, reliving the past, and passively watching television in the evening. Ironically, the program he is watching on this Sunday evening, as he gets out his ironing board to touch up his clothes with an iron, is "Beat the Clock." Little does anyone know the version of that game that John plays by himself every day.

The man we see is not an actor; he is for real. With only a canary for a companion, he has lived this way for nine years. Nor is he sick -- just old! The narrator reminds us, "If we don't care, who will learn to care?" A documentary film with very sparse but incisive narration!

AUDIENCES AND USES:

The one obvious use to which "I Think They Call Him John" can be put is to let it serve as the essential content of a program on the aging problem. The fact that John's only complication is age, apart from related matters of health, money, etc., makes the film a special challenge to those of all age levels who are ready to face up to the question of how to make life meaningful when socially one has all but been called obsolete. The film might also highlight subjects like loneliness, the need to be creative, human adequacy and inadequacy, alienation, leisure, individual dignity and freedom, and the divine spark in man. The film should have a wide audience for college age youth and adults, but conceivably some Junior and Senior High groups may find it fascinating.

QUESTIONS FOR DISCUSSION:

1. What are the factors that have created John's predicament?

2. How much has John himself been a factor of cause? Are there ways that he could help himself more?

3. Do you see anything humanly heroic about the way this man copes?

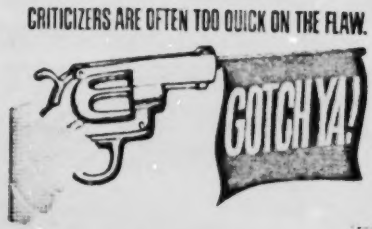
4. How well do you feel the film succeeds in making you stand in John's shoes?

5. In what direction does the answer lie to the problem of the increased numbers of aged?

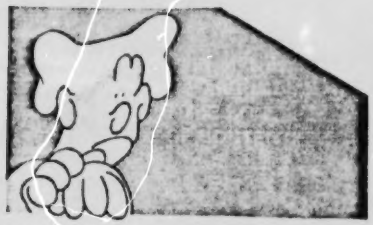
BEST COPY AVAILABLE

RESPECT FOR OTHERS

There Are Somethings You Can't Do Alone

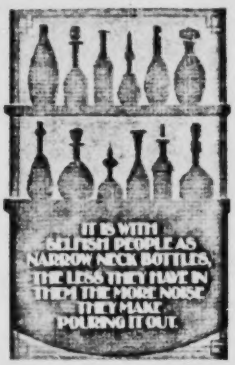


CRITICIZERS ARE OFTEN TOO QUICK ON THE FLAW.

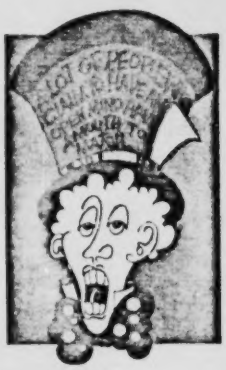


IN MANY ARGUMENTS THE BONE OF CONTENTION IS JUST ABOVE THE EARS.

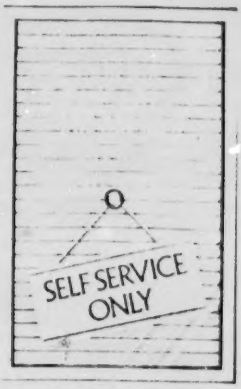
IF YOU WIN ALL THE ARGUMENTS YOU MAY LOSE ALL YOUR FRIENDS.



SELFISH PEOPLE — The Less They Have The More Noise They Make Pouring It Out.

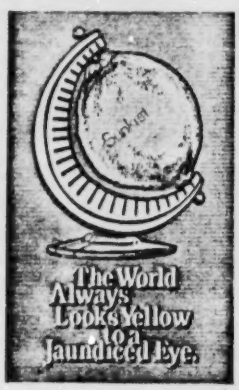


A Lot Of People Who Claim To Have An Open Mind Have A Mouth To Match.



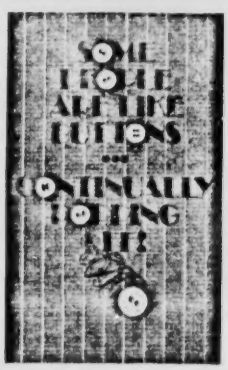
There Are Some Folks Who Act As If Life Is A Cafeteria — SELF SERVICE ONLY.

Inconsiderate Individuals Can Face The Music As Long As They Call The Tune.



The World Always Looks Yellow to a Jaundiced Eye.

DON'T LOOK FOR FAULTS AS IF THEY WERE BURIED TREASURE



SOME PEOPLE ARE LIKE BUTTONS... CONTINUALLY POPPING OFF!

ORDER FROM:

Spenco Medical Corp.
Box 8113
Waco, Texas
76714-8113

Posters Are Printed As A Unit
And This Set May Not Be Broken

88-195 ..... **$32.00**

One Track Minds Wouldn't Be So Bad... Except They're Usually On The Wrong Track.

KEEP YOUR WORDS NICE AND SWEET. Someday You May Have To Eat Them.

IN — is One Thing Stubborn People find Most Difficult to Give.